

SAN DIEGO COUNTY CMS
REQUEST FOR FORMULARY CHANGE FORM
Fax Completed Form to (855) 394-7927
Attention: Medical Management Services, Manager

DATE FORM COMPLETED: _____

REQUESTED BY: _____

CLINIC _____ SPECIALTY _____

PHONE NUMBER: _____ FAX NUMBER: _____ EMAIL: _____

COMPARABLE DRUG(S) ON FORMULARY:

1) _____

2) _____

DRUG INFORMATION

GENERIC NAME _____ BRAND NAME _____

MANUFACTURER _____ DOSAGE: _____

MEDICAL INDICATIONS: _____

PRECAUTIONS/ALERTS: _____

ADVANTAGES AND DISADVANTAGES: (YOU MAY ATTACH REFERENCES OR PUBLICATIONS THAT SUPPORT THE
EFFICACY OF THIS DRUG) _____

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FOR LIHP PROGRAM USE ONLY

COMMITTEE COMMENTS: _____

DRUG COST PER MONTH _____ POTENTIAL OVERALL COST _____

ADVANTAGE/DISADVANTAGE _____

ACCEPTED: _____ REJECTED: _____ DATE: _____

DATE ADDED TO FORMULARY _____